MEDICAL HISTORY

Patient First Name _____ Last name _____ Age _____

Name of Physician/ and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE OR HAVE YOU EVER HAD:	YES	NO
1. Hospitalization for illness or injury _____	☐	☐
2. An allergic reaction to		
☐ Aspirin, Ibuprofen, Acetaminophen, Codeine		
☐ Penicillin		
☐ Erythromycin		
☐ Tetracycline		
☐ Sulpha		
☐ Local anesthetic		
☐ Fluoride		
☐ Metals (nickel,gold,silver, _____)		
☐ Latex		
☐ Other _____		
3. Heart problems, or cardiac stent within the last six months	☐	☐
4. History of infective endocarditis _____	☐	☐
5. Artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. Pacemaker or implantable defibrillator _____	☐	☐
7. Artificial prosthesis (heart valve or joints) _____	☐	☐
8. Rheumatic or scarlet fever _____	☐	☐
9. High or low blood pressure _____	☐	☐
10. A stroke (taking blood thinners) _____	☐	☐
11. Anemia or other blood disorder _____	☐	☐
12. Prolonged bleeding due to a slight cut (INR >3.5) _____	☐	☐
13. Emphysema, sarcoidosis _____	☐	☐
14. Tuberculosis _____	☐	☐
15. Asthma _____	☐	☐
16. Breathing or sleep problems (i.e.snoring, sinus) _____	☐	☐
17. Kidney disease _____	☐	☐
18. Liver disease _____	☐	☐
19. Jaundice _____	☐	☐
20. Thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. Hormone deficiency _____	☐	☐
22. High cholesterol or taking statin drugs _____	☐	☐
23. Diabetes (HbA1c=) _____	☐	☐
24. Stomach or duodenal ulcer _____	☐	☐

	YES	NO
25. Digestive disorders (i.e. gastric reflux) _____	☐	☐
26. Osteoporosis/osteopenia (i.e. taking bisphosphonates) _	☐	☐
27. Arthritis _____	☐	☐
28. Glaucoma _____	☐	☐
29. Contact lenses _____	☐	☐
30. Head or neck injuries _____	☐	☐
31. Epilepsy, convulsion (seizures) _____	☐	☐
32. Neurologic problems (Attention deficit disorder) _____	☐	☐
33. Viral infections and cold sores _____	☐	☐
34. Any lumps of swelling in the mouth _____	☐	☐
35. Hives, skin rash, hay fever _____	☐	☐
36. Venereal disease _____	☐	☐
37. Hepatitis (type____) _____	☐	☐
38. HIV/AIDS _____	☐	☐
39. Tumor, abnormal growth _____	☐	☐
40. Radiation therapy _____	☐	☐
41. Chemotherapy _____	☐	☐
42. Emotional problems _____	☐	☐
43. Psychiatric treatment _____	☐	☐
44. Antidepressant medication _____	☐	☐
45. Alcohol/drug dependency _____	☐	☐
ARE YOU:		
46. Presently being treated for any other illness _____	☐	☐
47. Aware of a change in your general health _____	☐	☐
48. Taking medication for weight management (i.e. fen-phen)	☐	☐
49. Taking dietary supplements _____	☐	☐
50. Often exhausted or fatigued _____	☐	☐
51. Subject to frequent headaches _____	☐	☐
52. A smoker or smoked previously _____	☐	☐
53. Considered a touchy person _____	☐	☐
54. Often unhappy or depressed _____	☐	☐
55. Female – taking birth control pills _____	☐	☐
56. Female – pregnant _____	☐	☐
57. Male – prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

List all medications, supplements and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGES IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____